DSS
Strong Families - South Dakota's Foundation and Our Future

Department of Social Services
Division of Behavioral Health
3900 W. Technology Circle, Suite 1
Sioux Falls, SD 57106

Plan of Correction

Program Name: Behavior Management Systems, Inc.	**Date Submitted:** 09/10/2020	**Date Due:** 09/11/2020

Administrative POC-1

Rule #: 67:61:06:07	**Discharge policies.** Each agency shall have a written discharge policy. The policy includes the following: (1) Client behavior that constitutes reason for discharge at staff request; (2) The procedure for the staff to follow when discharging a client involved in the commission of a crime on the premises of the program or against its staff, consistent with the confidentiality of alcohol and drug abuse patient records, 42 C.F.R. § 2.12(c)(5) (June 9, 1987) including who shall must make the report to the appropriate law enforcement agency; (3) The procedure for the staff to follow when a client leaves against medical or staff advice, including offering the client discharge planning and continuation of care for substance abuse and any other condition and documentation of what was offered, consistent with the confidentiality of alcohol and drug abuse patient records, 42 C.F.R., Part 2 (June 9, 1987), confidentiality of alcohol and drug abuse patient records; (4) Prohibition against automatic discharge for any instance of non-prescribed substance use, or for any instance of displaying symptoms of mental or physical illness; and (5) The procedure for referrals for clients with symptoms of mental illness or a medical condition and those requesting assistance to manage symptoms.

Area of Noncompliance: The agency did not have a discharge policy.

Corrective Action (policy/procedure, training, environmental changes, etc.): Policy 7.09a Discharge from Services was created and will be provided to the BMS Board of Directors for approval at the next Board Meeting scheduled for September 22, 2020.	**Anticipated Date Achieved/Implemented:** **Date** 09/09/2020
Supporting Evidence: See attached Policy 7.09a Discharge from Services. Clinical Director will ensure training is provided to clinical staff on the policy.	**Person Responsible:** CEO, AEO, Clinical Director
How Maintained: This policy will be added to existing policies on file and training will be provided to clinical staff.	**Board Notified:** Y ☒ N ☐ n/a ☐

Administrative POC-2

Rule #: 67:61:05:01	Tuberculin screening requirements. Tuberculin screening requirements for employees are as follows: (1) Each new staff member, intern, and volunteer shall receive the two-step method of

	tuberculin skin test or a TB blood assay test to establish a baseline within 14 days of employment. Any two documented tuberculin skin tests completed within a 12-month period before the date of employment can be considered a two-step or one TB blood assay test completed within a 12 month period before employment can be considered an adequate baseline test. Skin testing or TB blood assay tests are not required if a new staff, intern or volunteer provides documentation of the last skin testing completed within the prior 12 months. Skin testing or TB blood assay tests are not required if documentation is provided of a previous position reaction to either test; (2) A new staff member, intern, or volunteer who provides documentation of a positive reaction to the tuberculin skin test or TB blood assay test shall have a medical evaluation and chest X-ray to determine the presence or absence of the active disease; (3) Each staff member, intern and volunteer with a positive reaction to the tuberculin skin test or TB blood assay test shall be evaluated annually by a licensed physician, physician assistant, nurse practitioner, clinical nurse specialist, or a nurse and a record maintained of the presence or absence of symptoms of *Mycobacterium* tuberculosis. If this evaluation results in suspicion of active tuberculosis, the licensed physician shall refer the staff member, intern, or volunteer for further medical evaluation to confirm the presence or absence of tuberculosis; and (4) Any employee confirmed or suspected to have infectious tuberculosis shall be restricted from employment until a physician determines that the employee is no longer infectious.

Area of Noncompliance: The documentation of the first required TB skin test was not completed within the 14 days of hire in two out of two personnel records reviewed.	
Corrective Action (policy/procedure, training, environmental changes, etc.): Standard Operating Procedure 7.18a has been changed to 7.19 Personnel Tuberculosis Infection Control & Screening and updated to have all new hires in the Full Circle program obtain the required TB skin test from an outside source and will be part of the orientation process.	**Anticipated Date Achieved/Implemented:** **Date** 9/09/2020
Supporting Evidence: See attached SOP 7.19 Personnel Tuberculosis Infection Control & Screening.	**Person Responsible:** CEO, AEO, Human Resources Director, Full Circle Director, Full Circle Nurse and Employee
How Maintained: An outside provider will used for the testing within the first 14 days and will provide results to Human Resources. Tracking will be implemented within our employee management system for tracking purposes.	**Board Notified:** Y ☒ N ☐ n/a ☐

Administrative POC-3	
Rule #: 67:62:08:03	**Rule Statement:** **Closure and storage of case records.** The agency shall have written policies and procedures to ensure the closure and storage of case records at the completion or termination of services including:

	(1) The identification of staff positions or titles responsible for the closure of case records within the agency and the MIS; (2) Procedures for the closure of records for inactive clients, that are clients who have had no contact by phone or by person with the agency for a time period of no longer than six months; and (3) Procedures for the safe storage of client case records for at least six years from closure.

Area of Noncompliance: The agency does not have a policy regarding the closure of inactive clients who have not had contact for longer than six months.

Corrective Action (policy/procedure, training, environmental changes, etc.): Standard Operating Procedure 3.10 updated to include closure and storage of records.	**Anticipated Date Achieved/Implemented:** **Date** 09/09/2020
Supporting Evidence: See attached Policy 3.10 Closure and Storage of Client Records. Clinical Director will ensure training is provided to clinical staff on the SOP 3.10.	**Person Responsible:** CEO, AEO, Clinical Director
How Maintained: Updates will be provided to all clinical supervisors within the agency for understanding of the standard and expectations.	**Board Notified:** Y ☒ N ☐ n/a ☐

Client Chart POC-1	
Rule #: 67:61:17:08	**Rule Statement:** **Treatment plan review -- Six month review.** Treatment plans shall be reviewed in at least six month intervals and updated if needed. Treatment plan reviews shall include a written review of any progress made toward treatment goals or objectives, significant changes to the treatment goals or objectives, and a justification for the continued need for mental health services. Treatment plan reviews may be documented in the progress notes or other clinical documentation; however, any changes in the client's treatment plan goals or objectives shall be documented in the treatment plan. Treatment plan reviews shall include the mental health staff's signature, credentials, and date.

Area of Noncompliance: In review of the CYF, MH Outpatient, and CARE, treatment plan reviews, one or more elements were missing from the reviews.

Corrective Action (policy/procedure, training, environmental changes, etc.): Current Treatment plan review process will remain in effect until new Electronic Health Record is implemented in early 2021. When EHR is implemented, sign off and review process will include one Treatment plan review document meeting Administrative rule standards and include all required pieces of the review. Training to all Clinical Supervisors and Staff members will be updated to require Treatment plan reviews are written minimally every 6 months. Staff will be asked to complete these prior to the 6 month review date even if the	**Anticipated Date Achieved/Implemented:** **Date** Anticipated spring of 2021

client is unavailable for any reason. IAP goals will then be updated when the client returns for service.	
Supporting Evidence: Clinical Director will implement training and follow through with clinical supervisors and Quality Assurance Auditors effective immediately.	**Person Responsible:** Clinical Director
How Maintained: This expectation will be clarified with the internal audit team. This team is meeting on 9/15/2020 and information on this expectation will be implemented at that time for staff, supervisors and quality assurance auditors.	**Board Notified:** Y ☒ N ☐ n/a ☐

Client Chart POC-2	
Rule #: 67:61:07:10 and 67:62:08:14	**Rule Statement:** **67:61:07:10 Transfer or discharge summary.** An addiction counselor or counselor trainee shall complete a transfer or discharge summary for any client within five working days after the client is discharged regardless of the reason for discharge. A transfer or discharge summary of the client's problems, course of treatment, and progress toward planned goals and objectives identified in the treatment plan is maintained in the client case record. A process shall be in place to ensure that the transfer or discharge is completed in the MIS. When a client prematurely discontinues services, reasonable attempts shall be made and documented by the agency to re-engage the client into services if appropriate. **67:62:08:14. Transfer or discharge summary.** A transfer or discharge summary shall be completed upon termination or discontinuation of services within five working days. A transfer or discharge summary of the client's problems, course of treatment, and progress toward planned goals and objectives identified in the treatment plan shall be maintained in the client case record. A process shall be in place to ensure that the transfer or discharge is completed in the MIS. If a client prematurely discontinues services, reasonable attempts shall be made and documented by the center to re-engage the client into services if appropriate.
Area of Noncompliance: In review of the SUD and MH charts at least one of the following elements listed above were missing.	
Corrective Action (policy/procedure, training, environmental changes, etc.): Counselors will complete transfer/discharge within 5 working days. Primary counselor or admission specialist will make reasonable efforts to contact the client, or referral source and document efforts.	**Anticipated Date Achieved/Implemented:** **Date** 9/09/2020
Supporting Evidence: Training has been provided to Primary clinical staff and admission specialist.	**Person Responsible:** Primary clinical staff, Program Director, Clinical Director, Quality Assurance Audit team members.

How Maintained: This expectation will be reviewed and monitored through monthly quality assurance audits. Individual staff who are not meeting this expectations will receive additional training or plans for improvement.	**Board Notified:** Y ☒ N ☐ n/a ☐

Client Chart POC-3	
Rule #: 67:61:07:12	**Rule Statement:** **Tuberculin screening requirements.** A designated staff member shall conduct tuberculin screening for the absence or presence of symptoms with each client newly admitted to outpatient treatment, intensive outpatient, day treatment, clinically-managed low intensity residential treatment, clinically managed detoxification, and intensive inpatient treatment within 24 hours of admission to determine if the client has had any of the following symptoms within the previous three months: (1) Productive cough for a two to three-week duration; (2) Unexplained night sweats; (3) Unexplained fevers; or (4) Unexplained weight loss. Any client determined to have one or more of the above symptoms within the last three months shall be immediately referred to a licensed physician for a medical evaluation to determine the absence or presence of active disease. A Mantoux skin test may or may not be done during this evaluation based on the opinion of the evaluating physician. Any client confirmed or suspected to have infectious tuberculosis shall be excluded from services until the client is determined to no longer be infectious by the physician. Any client in which infectious tuberculosis is ruled out shall provide a written statement from the evaluating physician before being allowed entry for services.
Area of Noncompliance: In review of the agency's SUD charts: two out of three outpatient charts, three out of four 3.1 charts, and two out of four 3.7 charts did not have the TB screen completed within 24 hours of admission.	
Corrective Action (policy/procedure, training, environmental changes, etc.): Program Nurse will complete the required screening within 24 hours of admission and complete the TB screening document in the EHR. Any new Nursing personnel will get training on the TB screening process.	**Anticipated Date Achieved/Implemented:** **Date** 9/09/2020
Supporting Evidence: Program Director has provided training and clarification to existing nursing staff and Quality Assurance Audit team members are monitoring consistency.	**Person Responsible:** Full Circle Nurse, Full Circle Program Director, Clinical Director, Quality Assurance Audit team members.
How Maintained: Quality Assurance Audits will note if the screening document is not present in the clinical chart at time of intake. Compliance at less than 90% will result in plan for improvement for the nursing staff.	**Board Notified:** Y ☒ N ☐ n/a ☐

Client Chart POC-4	
Rule #: 67:61:18:05	**Rule Statement:** **Intensity of services.** A medically-monitored intensive inpatient treatment program for adults shall provide daily to each client a combination of individual, group, or family counseling which shall total a minimum of 21 hours per week. The program shall also provide a minimum of nine hours of additional services on specialized topics that address the specific needs of the client. The additional services shall be identified on the client's treatment plan or continued stay review. These services shall be provided by an individual trained in the specific topic presented. A medically monitored intensive inpatient treatment program for adolescents shall include at least 15 hours per week of any combination of individual, group, or family counseling services.
Area of Noncompliance: In review of the SUD 3.7 charts, four out of four client charts reviewed did not have documentation to support the minimum number of service hours were being met each week.	
Corrective Action (policy/procedure, training, environmental changes, etc.): EHR system is being utilized to ensure required minutes are being met. Counselors are now reviewing charts to ensure accuracy of minutes and Program Director is reviewing EHR document weekly.	**Anticipated Date Achieved/Implemented:** **Date** 9/09/2020
Supporting Evidence: Program Director provided training and clarification on minutes needed for 3.7 services and has implemented the oversight of this requirement.	**Person Responsible:** Primary Counselors, Program Director, Clinical Director
How Maintained: A two check system by the primary counselor and program director are being used each week to ensure minutes are being met.	**Board Notified:** Y ☒ N ☐ n/a ☐

Client Chart POC-5	
Rule #: 67:61:18:02	**Rule Statement:** **Medical evaluations and vital signs.** At a minimum, the program shall complete the following: 1) At the time of admission, each client's blood pressure, pulse, and respiration shall be evaluated and recorded in the client's case record by staff trained to perform these tests; 2) Within 8 hours after admission, each client shall receive a medical evaluation conducted by an RN or an LPN. The results of this medical evaluation shall be provided to the program physician for the purpose of determining whether the client needs immediate and a more extensive examination to determine the appropriateness of the admission and the program physician's approval shall be documented in the client's case record: a) The medical evaluation includes:

	i) A second reading of blood pressure, pulse, and respiration; ii) Mental and emotional status; iii) Any bruises, lacerations, cuts, wounds, or other medical conditions; iv) Current medication use, particularly sedative use and medications being carried by the client; and v) Any history of diabetes, seizure disorders including epilepsy, delirium tremens, and any history of convulsive therapies, e.g., electroconvulsive or insulin shock treatments; and 3) Within 72 hours after admission, each client shall have: a) A complete blood count and urinalysis; and b) A complete physical examination by or under the supervision of a licensed physician, who shall also evaluate the results of the tests conducted.

Area of Noncompliance: In review of the SUD 3.7 charts, four out of four charts were missing a second reading of blood pressure, pulse, and respiration within 8 hours in which the time was documented. All four charts contained vital signs taken however it was unclear at which time they were obtained.

Corrective Action (policy/procedure, training, environmental changes, etc.): Client MAR's have been updated to reflect a new section designated for vitals that include the date/time for 3 sets of admission vitals.	**Anticipated Date Achieved/Implemented:** **Date** 9/09/2020
Supporting Evidence: See attached MAR document.	**Person Responsible:** Med trained staff, Full Circle Nurse, Program Director
How Maintained: All staff in the program have been trained on recording the vitals in the update format. Nursing and Program Supervisors will monitor for accuracy.	**Board Notified:** Y ☒ N ☐ n/a ☐

Client Chart POC-6

Rule #: 67:61:18:02	**Rule Statement:** **Medical evaluations and vital signs.** At a minimum, the program shall complete the following: 3) At the time of admission, each client's blood pressure, pulse, and respiration shall be evaluated and recorded in the client's case record by staff trained to perform these tests; 4) Within 8 hours after admission, each client shall receive a medical evaluation conducted by an RN or an LPN. The results of this medical evaluation shall be provided to the program physician for the purpose of determining whether the client needs immediate and a more extensive examination to determine the appropriateness of the admission and the program physician's approval shall be documented in the client's case record: a) The medical evaluation includes: vi) A second reading of blood pressure, pulse, and respiration; vii) Mental and emotional status; viii) Any bruises, lacerations, cuts, wounds, or other medical conditions; ix) Current medication use, particularly sedative use and

	medications being carried by the client; and x) Any history of diabetes, seizure disorders including epilepsy, delirium tremens, and any history of convulsive therapies, e.g., electroconvulsive or insulin shock treatments; and 3) Within 72 hours after admission, each client shall have: a) A complete blood count and urinalysis; and b) A complete physical examination by or under the supervision of a licensed physician, who shall also evaluate the results of the tests conducted.

1. **Area of Noncompliance:** In review of the SUD 3.7 charts, two out of four charts were missing documentation of the physical exam including the complete blood count and urinalysis requirement within 72 hours of admission.

Corrective Action (policy/procedure, training, environmental changes, etc.): Nurse will schedule medical evaluation within 72 hours, any extenuating circumstances will be documented, If client is unable to get in with primary care provider, back up medical evaluations will be provided by Community Health Center. Results of appointment will be scanned into client chart.	**Anticipated Date Achieved/Implemented:** **Date** 9/09/2020
Supporting Evidence: Nursing staff has been provided additional training on the expectations of having clients seen within 72 hours and understands the expectation going forward.	**Person Responsible:** Full Circle Nurse, Program Director, Clinical Director, Quality Assurance Audit team members.
How Maintained: Compliance with the 72 hour expectation will be monitored through the monthly Quality Assurance process.	**Board Notified:** Y ☒ N ☐ n/a ☐

Client Chart POC-	
Rule #: 67:62:13:02	**Services provided by the center.** Services should be provided in a location preferred by the client, including settings outside the center. Services should be provided within an integrated system of care. Services shall be provided according to the individualized needs and strengths of the client and shall be responsive to cultural differences and special needs. The following IMPACT services shall be provided according to the individualized needs of the client; (1) Integrated assessment, evaluation, and screening; (2) Crisis assessment and intervention services available 24 hours per day, seven days per week; (3) Case management; (4) Psychiatric services, with the primary purpose of prescribing or reviewing a client's use of pharmaceuticals, including psychiatric assessments, treatment, and prescription of pharmacotherapy; (5) Psychiatric nursing services including components of physical assessment,

	medication assessment and monitoring, and medication administration; (6) Symptom assessment and management, including medication monitoring and education; (7) Individual therapy or counseling; (8) Group therapy; (9) Recovery support services; (10) Direct assistance to ensure ongoing opportunities for the client to obtain the basic necessities of daily life and perform basic daily living activities; (11) Psychosocial rehabilitative services provided on an individual or group basis to assist the client to gain or relearn self-care, interpersonal, and community living skills needed to live independently, sustain psychiatric stability, and progress towards recovery; (12) Liaison services to facilitate treatment planning and coordination of services between mental health and other entities; (13) Encouragement for active participation of family and supportive social network; and (14) Collateral contacts. IMPACT services may not exceed a ratio of at least one primary therapist for Every 12 clients served. A center shall provide clients with an average of 16 contacts per month with IMPACT staff and more often if clinically appropriate.

Area of Noncompliance: In review of the IMPACT charts, three out four charts reviewed did not have documentation of at least 16 contacts per month.	
Corrective Action (policy/procedure, training, environmental changes, etc): A tracking system has been designed to notate all contacts with client including medication drops and short visits as well as billable services. Training has been provided to staff to encourage more meaningful contacts during the week.	**Anticipated Date Achieved/Implemented:** **Date** 9/09/2020
Supporting Evidence: See attached IMPACT Client Tracking document. This document is being reviewed during weekly team meetings.	**Person Responsible:** Program Director, IMPACT Clinical Supervisor, IMPACT Team Coordinator, Clinical Director
How Maintained: BMS added a team coordinator/supervisor to assist with tracking and monitoring the fidelity to the IMPACT model. Team Coordinator will monitor and maintain the tracking system to ensure the ability to document all contacts with IMPACT clients.	**Board Notified:** Y ☒ N ☐ n/a ☐

Program Director Signature:	Date:
Linda Kadrlabai, CEO, BNIS	9/10/2024

Send Plan of Correction to:

Accreditation Program
Department of Social Services
Division of Behavioral Health
3900 W. Technology Circle, Suite 1
Sioux Falls, SD 57106
DSSBHAccred@state.sd.us

BEHAVIOR MANAGEMENT SYSTEMS, INC.
POLICY OF THE BOARD OF DIRECTORS

SUBJECT: Discharge From Services		SECTION NAME/NO.: Service Delivery 7.09a	
EFFECTIVE DATE: 9/9/2020	SUPERSEDES:	REFERENCE: ARSD 67:61:06:07 & 67:62:08:03	
REVIEW DATE:	REVIEW DATE:	REVIEW DATE:	REVIEW DATE:

POLICY:

All client discharges will have a written summary providing the information regarding a client's progress and the circumstances pertaining to discharge and attempts to re-engage client in services. Clients may not be discharged from services automatically due to substance use or displaying symptoms of mental or physical illness. Inactive clients will be discharged from services within 6 months if attempts to re-engage in service are unsuccessful.

DISCUSSION:

While clients are participating in services, staff will assesses on a continuous basis the need for continued services based upon appropriateness, successful completion of treatment plan goals, or need to transfer to alternative care, prior to any discharge staff will seek clinical supervision to explore possible interventions and appropriateness of discharge.

Our clients enter care at a variety of different stages of change and with ever changing stressors, the likelihood of a client discontinuing services contrary to advice should be anticipated. In these situations, staff are expected to make attempts to re-engage clients in services, support and make reasonable efforts to ensure coordination of care, and/or assist with re-admission to services should the client request to return.

On the rare occasion that client behavior necessitates a discharge from services at the request of staff, circumstances will be explored with the clinical supervisor, program director and/or clinical director. Behaviors that will warrant consideration include but are not limited to ethical, criminal, safety or liability concerns. Referral to a more appropriate level of care and services will be offered and coordinated whenever possible.

Discharge of a client engaged in the commission of a crime on the premises of the program or against its staff shall be immediately staffed with the program or clinical director and will be consistent with the confidentiality of alcohol and drug abuse patient records as required by federal law. Program procedures will guide reporting and response expectations based on the severity of the allegation.

Programs will maintain knowledge and access to referral sources for clients in need of additional supports for mental health or physical needs. Any client requesting assistance in obtaining these services to manage symptoms of mental health or physical health needs will be afforded the

opportunity to explore options and receive referrals as appropriate.

Clients will not be discharged solely for engagement in non-prescribed substance use or for any instance of displaying symptoms of mental or physical illness.

The Support Services Manager will distribute reports to the primary clinicians on a monthly basis regarding any client who has been inactive in services for longer than six months. The list will be reviewed by the clinician to determine the need for discharge or attempt to re-engage client in services.

BEHAVIOR MANAGEMENT SYSTEMS, INC.
STANDARD OPERATING PROCEDURE

SUBJECT: Personnel Tuberculosis Infection Control & Screening		SECTION NAME/NO.: 7.19	
EFFECTIVE DATE: 9/9/20	CEO APPROVAL:	SUPERSEDES: 5/1/14 7.18a	
REVIEW DATE:	REVIEW DATE:	REVIEW DATE:	REVIEW DATE:

APPLICATIONS:

Programs and employees, interns, or volunteers providing services in all chemical dependency services.

PURPOSE:

To conduct tuberculin screening for all new employees, interns, and volunteers involved in the chemical dependency services within the company.

RESPONSIBILITIES:

Human Resources: Track the completing of the two-step skin test and annual skin tests. Notify staff of tuberculosis skin testing requirement and company procedures for completion. Monitor any annual employee testing needed conducted and alert employee of annual test review. Coordinate testing for new employees, interns, or volunteers and provide authorization of services documentation to employees, interns, or volunteers at the time of hire or annually if needed.

Staff: Complete first step of the two-step skin test within 14 days of employment. Complete annual skin tests thereafter if having received a prior positive skin test.

PROCEDURES:

1. Human Resources will provide authorization of services to all new employees, intern, or volunteer upon their start date in chemical dependency services and appointment scheduling information for testing.

2. Any new employee, intern, or volunteer providing chemical dependency services shall receive a two-step method of Mantoux skin test to establish a baseline within 14 days of employment. Any two step documented Mantoux skin tests completed

within a 12-month period from the date of hire shall be considered a two-step. Skin testing is not necessary if documentation is provided of a previous negative result.

3. Any employee who has a positive reaction to the Mantoux skin test shall obtain a medical evaluation and chest X-ray to determine the absence or presence of the active disease.

4. Any employee, intern, or volunteer with a positive reaction to the tuberculin skin test shall be evaluated annually by a licensed physician, physician assistant, nurse practitioner, clinical nurse specialist, or a nurse and a record maintained of the presence or absence of symptoms of Myobacterium tuberculosis. If this evaluation results in suspicion of active tuberculosis, the licensed physician shall refer the staff member, intern, or volunteer for further medical evaluation to confirm the presence or absence of tuberculosis.
5. Any employee exposed to an infectious case of tuberculosis shall be screened within 24 hours by a Mantoux skin test, or chest X-ray if indicated, as recommended and directed by the South Dakota Department of Health, TB Control Program.

6. Human Resources shall track the completion of the two-step skin test and need for any annual skin tests. Human Resources shall notify the employee when the employee is coming due for an annual skin tests.

BEHAVIOR MANAGEMENT SYSTEMS, INC.
STANDARD OPERATING PROCEDURE

SUBJECT: Closure & Storage of Client Records		SECTION NAME/NO.: Organizational Administration 3.10	
EFFECTIVE DATE: 9/9/20	CEO APPROVAL:	SUPERSEDES: 11/1/07 3.10	
REVIEW DATE:	REVIEW DATE:	REVIEW DATE:	REVIEW DATE:

APPLICATIONS:

All Divisions

PURPOSE:

To ensure the proper closure and storage of client records that document services provided by clinical staff, to include planned discharges or closure of inactive clients.

RESPONSIBILITIES:

1. *Clinical Director*: To establish Standard Operating Procedures related to client records and services.

2. *Division Director/Clinical Supervisor*: To supervise the implementation of the Standard Operating Procedure and ensure staff compliance with it.

3. *Support Staff/Clinical Staff*: To follow the Standard Operating Procedure related to the storage checkout and disposition of client records.

4. *Support Staff/Office Manager or designated staff*: To follow the Standard Operating Procedure for proper closure and storage of client records.

PROCEDURES:

I. Closure of Clinical Records.

   a. Clinical records in paper or electronic form will be closed out by the Clinical staff or Clinical Supervisor responsible for the record for all clients who have had no contact, by phone, telehealth technology or in person, by the agency for a time period of no longer than six months.

II. Clinical Paper Record Storage:

a. Clinical paper records of clients open for services shall be retained for storage at the service site. Clinical records of clients discharged from services shall have their paper chart, if applicable, transferred to the storage site as designated for each office. Clinical paper records requiring permanent retention should be forwarded to the Elk Street office for permanent storage.

b. Client paper records documenting services for clients that have been discharged from services for more than one year are to be transferred to Record Storage Solutions, 413 6th Street, Rapid City, South Dakota for storage. Before charts are sent to Record Storage Solutions the following procedure should be adhered to:

1. Prior to closing charts clinicians should indicate whether the records should be held in permanent storage based on the criteria listed under section IV, letter a.
2. Designated support staff at each site location will keep a log of charts or boxes to be transferred to Record Storage Solutions.
3. When a set of records is due for destruction a list of records to be destroyed will be listed on the Records Destruction form and signed by the appropriately authorized personnel.

II: Destruction of Paper Clinical Records

a. Entire clinical paper records of services shall remain intact for a minimum of seven (7) years following discharge from services.

b. The clinical paper record of services provided to children or adolescents shall remain intact at least until the client is 24 years of age. If a client paper record documents services provided to a family, the client paper record shall remain intact until the youngest member of the family is at least 24 years of age.

c. During the eighth year, or after the minor child has reached the age of 24, a client paper record has been closed for clinical services, the record shall be destroyed by Record Storage Solutions per approved destruction procedures, unless it has been tagged for permanent retention by the clinical staff who provided services. No records will be destroyed without prior authorization of the CEO, Finance Director or the Clinical Director signing and dating the "Records Storage Information" sheet.

d. Critical information that shall be maintained from all client records shall be stored electronically on data servers prior to the destruction of records includes the following:

- Client name
- Date of birth
- Date of initial assessment
- Date of discharge
- Client identification number (CID #)

III: Storage of Electronic Clinical Records

a. Entire electronic clinical records of services provided for clients shall remain intact permanently.

b. Active electronic client records will be stored within the Behavioral Health electronic record software until the client record is discharged.

c. Discharged client electronic records will be stored within the Archive View within the Behavioral Health electronic record software. A discharged client record will be transferred to the Archive View on the 15th day of the following month it was discharged in.

d. If/when a clinical staff determines that an electronic clinical record shall be retained for permanent retention based on the below criteria in section IV, letter a., the electronic record will be marked for "Permanent Retention". That record will then be transferred to the Archive view and the Permanent Retention view.

e. If/when a clinical staff determines that an electronic clinical record shall be retained for permanent retention based on the below criteria in section IV, letter a., an electronic email notification will be generated and sent to the staff maintaining the master listing of permanent records upon discharge of the client record.

f. The staff maintaining the master listing of permanent records will update the master listing upon receiving email notification.

IV: Records for Permanent Retention

a. Clinical staff may identify that the record of services provided certain clients be tagged for permanent retention in storage. Examples of records that may be considered for permanent retention include, but are not limited to, the records of clients who have:

- Stalked staff;
- Demonstrated or threatened violence toward staff;
- Committed or threatened arson;
- Murdered someone, or;
- Is an adult registered Sexual Offender

The decision to permanently retain a clinical record should be at the discretion of the clinical staff providing services, a Division Director, the Clinical Director or the Chief Executive Officer.

b. All clinical charts that have been labeled as "Permanent Retention" charts will be included on a master spreadsheet stored under the ZPermanentRecords folder accessible by the Chief Executive Officer, Associate Executive Officer, Clinical Director and staff maintaining the spreadsheet. The spreadsheet will indicate the client name, client CID#, client Date of Birth, client's status; open or closed, closed date, if applicable, reason for retaining chart permanently and location of client chart.

MAR

Client Name:															Allergies:								Month:			Year	2020					
Birthdate:			Pregnant:			Born:																	Physician:										
Admitted:			Facility:																				Pharmacy:										
Medication	Time	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Vital Signs every other week with time documented Daily Temp	T																															
	P																															
	R																															
	B/P																															
Weights every other week																																
	W																															
	TIME																															

Initial	Signature	Initial	Signature	Initial	Signature

IMPACT Client Contact Tracking

		Week 1		Week 2		Week 3		Week 4		Week
Client	Staff	Contacts	Med	Contacts	Med	Contacts	Med	Contacts	Med	Contacts
A	AN	4	14	4		4		4		4
b	AN	3	12	3		3		3		3
c	AN	4	7	4		4		4		4
d	AN	2	9	2		2		2		2
e	AN	4	14	4		4		4		4
	AN									
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